

Employer Compliance Alert



“Meeting employee needs is a challenge.
Meeting the government’s is critical.”



▶ AGENCIES CLARIFY “GRANDFATHERING” UNDER HEALTH CARE REFORM

As explained in our [May 2010 article](#), the Affordable Care Act imposed a number of benefit mandates on employer health plans, most of which will take effect with the first plan year beginning after September 23, 2010. However, certain plans that were in existence on March 23, 2010 (the Act’s enactment date) enjoy limited “grandfather” protection. Some of the benefit mandates do not apply at all to these grandfathered plans, while others apply only at a later date. Unfortunately, the Act did little to define the scope of this grandfather protection. The three agencies charged with administering the Act have now issued interim final regulations providing useful guidance on this topic.

Advantages of Grandfathered Status

Even *grandfathered* plans must comply with many of the Act’s benefit mandates. Such plans are exempt, however, from the following mandates:

- Required coverage for emergency services at in-network levels;
- Required first-dollar coverage for certain preventive services (immunizations and screenings), subject to no deductible;
- A prohibition on restricting the designation of primary care providers or requiring referrals for OB/GYN services;
- Required coverage of routine expenses for participation in clinical trials;
- Enhanced claim appeal procedures, including implementation of an external appeals process; and
- A prohibition on discriminating in favor of highly compensated individuals (i.e., applying the same nondiscrimination rules to both insured and self-funded plans).

Due to these exemptions, many plan sponsors will want to retain their plan’s grandfathered status for as long as that proves to be feasible.

General Requirements for Grandfathered Status

In addition to being in effect on March 23, 2010, a grandfathered plan must avoid taking any action that would undermine its grandfathered status. The types of actions that would cause a plan to lose

Employer Compliance Alert

its grandfathered status are described in the next section of this Alert. However, the regulations also condition grandfathered status on the sponsor taking the following *affirmative* steps:

- Including “in any plan materials provided to a participant or beneficiary that describes the benefits provided under the plan” (such as a summary plan description) a statement that the plan believes it is a grandfathered health plan within the meaning of Section 1251 of the Act. This statement must also provide contact information for questions and complaints. The regulations include model language that may be used to satisfy this disclosure requirement.
- Maintaining records that document the terms of the plan as in effect on March 23, 2010, along with any other documents necessary to verify, explain, or clarify the plan’s status as a grandfathered health plan. Those records must then be made available for examination upon request by a participant, beneficiary, or government agency.

Losing Grandfathered Status

The regulations are particularly helpful in listing the steps a plan may – or may not – take without losing its grandfathered status. For instance, grandfathered plans have substantial flexibility to add or remove covered individuals. Employees may be allowed to add their dependents, the plan may enroll new hires, and (clarifying a question left unanswered by the statutory language) the plan may enroll *existing* employees who had simply declined to enroll in the past. Moreover, subject to certain “anti-abuse rules,” employees may be *transferred* between plans (or plans may be merged) without thereby undermining the plans’ grandfathered status.

A *self-funded* plan may also substitute a new third-party administrator for the TPA that was in place on March 23, 2010. By contrast, an *insured* plan will generally lose its grandfathered status if it enters into a new policy, certificate, or contract of insurance. Presumably, simply renewing a policy with an existing carrier will *not* cause a loss of grandfathered status.

The regulations also allow for changes in a plan’s benefit structure, so long as none of those changes is described in the following list:

- Eliminating all or substantially all benefits to diagnose or treat a particular condition;
- Increasing a coinsurance or other percentage-based cost-sharing requirement above the level in effect on March 23, 2010;
- Increasing a fixed-dollar cost-sharing requirement (other than a copayment), such as an annual deductible or out-of-pocket limit, by a total percentage – measured from March 23, 2010 – that exceeds the sum of the medical inflation rate plus fifteen percentage points;
- Increasing a copayment by an amount that exceeds the *greater* of (1) the amount just described for other fixed-amount cost-sharing requirements, or (2) \$5 increased by the medical inflation rate since March 23, 2010;
- Decreasing the rate of employer contributions to the plan (for *any* tier of coverage, such as employee-only or family) by more than five percentage points below the rate that was in effect on March 23, 2010; or
- Adopting or decreasing an annual benefit limit, with the specific rules depending on whether the plan had already imposed an annual or lifetime limit as of March 23, 2010.

Employer Compliance Alert

As of now, other types of benefit modifications will *not* cause a loss of grandfathered status. For instance, the regulations' preamble asks for comments on whether changing a plan's network provider, changing from an insured to a self-funded plan, or changing a prescription drug formulary should be added as events causing a loss of grandfathered status. The preamble assures us, however, that any such change in the regulations would be applied only prospectively.

The regulations provide that the grandfathering rules apply separately to each "benefit package" made available under a health plan. Thus, a plan offering both an HMO and a PPO option might choose to modify the PPO's deductible or copayment in a way that would cause the PPO to lose its grandfathered status, without thereby forfeiting the HMO's grandfathered status.

Collectively Bargained Plans

The Act contains special grandfathering provisions for plans maintained pursuant to a collective bargaining agreement. Because these statutory provisions concerning collectively bargained plans were inartfully drafted, they are subject to differing interpretations. The regulations provide needed clarification in this area – though sometimes in rather surprising ways.

For example, the drafters of the regulations take literally the Act's reference to "health *insurance* coverage" maintained pursuant to a collective bargaining agreement. The regulations therefore limit the special grandfathering rules for collectively bargained plans to those that are fully insured. Although *self-funded* collectively bargained plans may be grandfathered under the rules described above, they do not enjoy any additional protection under these collectively bargained rules.

Accordingly, if a self-funded collectively bargained plan is modified in any way that would cause a *non-bargained* plan to lose its grandfathered status, the collectively bargained plan will do so as well. Even granting that this approach tracks the statutory language, one has to question the policy basis for favoring *insured* over *self-funded* plans in this fashion.

Moreover, some practitioners had read the Act's provisions concerning collectively bargained plans as providing a type of "super-grandfathering." That is, the language could be read to provide that *none* of the benefit mandates would apply to a collectively bargained plan – even those that would otherwise apply to a *grandfathered* plan – until the expiration of the last of the relevant collective bargaining agreements (i.e., those in effect on March 23, 2010). The regulations clearly reject this interpretation. A collectively bargained grandfathered plan (even an *insured* one) will be subject to the Act's benefit mandates at the same time as other grandfathered plans. Thus, for example, as of the first plan year beginning after September 23, 2010, even a collectively bargained plan must eliminate all preexisting condition limitations for dependents under age 19, remove any lifetime limits on "essential benefits," and make coverage available until a child's 26th birthday (unless the child has access to other employer coverage).

On the other hand, a fully insured plan that enjoys this special grandfather protection for collectively bargained plans may be amended in ways that would otherwise violate the restrictions summarized

Employer Compliance Alert

above without immediately losing its grandfathered status. Instead, it would remain grandfathered until the expiration of the last of the relevant bargaining agreements.

The regulations clarify one other point concerning collectively bargained plans. Some had read the statute to say that such a plan would automatically lose its grandfathered status upon the expiration of the last bargaining agreement that was in effect on March 23, 2010. Again, the regulations reject this approach. Instead, such a plan's status will be determined by comparing the terms of the plan in effect at that point to the terms in effect on March 23, 2010 – and then applying the analysis set forth above. That is, did any benefit changes exceed the levels described above? If so, the plan will no longer be grandfathered. Otherwise, the grandfather protection will remain in place until such a change is adopted.

Oddly, the regulations also note that a collectively bargained plan may change insurance carriers prior to the expiration of the last of the relevant bargaining agreements *without* causing a loss of its grandfathered status once that bargaining agreement expires. No policy basis is provided for this exception to the general rule noted above.

Limited Transition Relief

Recognizing that plan sponsors may have been attempting to stay within the Act's grandfather provision even in the absence of regulatory guidance, these regulations provide limited transition relief. In particular:

- Plan changes adopted after March 23, 2010, will be treated as in effect on that date if they were made pursuant to either a legally binding contract or state insurance department filing that was made *prior* to that date.
- Plans that adopted changes after March 23, 2010, will now have a "grace period" during which they may revoke those changes and thereby retain their grandfathered status. This grace period will end on the first day of the first plan year beginning after September 23, 2010.
- For the period before these regulations were released, the agencies "will take into account good-faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard changes ... that only modestly exceed" the types of changes allowed by grandfathered plans.

Recommendations

Armed with this regulatory guidance, sponsors of health plans that wish to retain their grandfathered status should immediately review any changes adopted since March 23, 2010. Some of those changes may need to be revoked during the grace period described above.

Sponsors should also take this guidance into account when determining whether to make further changes to the plan. In doing so, they should consider whether the cost savings associated with plan modifications might more than offset the costs of complying with the benefit mandates associated with the loss of grandfathered status.

Employer Compliance Alert

Given some of the surprises contained in these regulations, *collectively bargained* plans may need to entirely rethink their proposed approach to the Act. Those that are *self-funded* should understand that they enjoy no special protection as a result of their collectively bargained status. And even *insured* plans that are collectively bargained should be prepared to comply with all of the benefit mandates to which other grandfathered plans are subject – generally, by the first day of the plan year beginning after September 23, 2010.

Finally, sponsors who want to retain their plan's grandfathered status should not overlook the notification and document retention requirements. For instance, before the first plan year beginning after September 23, 2010, they will want to supplement the plan's summary plan description to include either the IRS model language or similar language tailored to the plan's particular situation.

Spencer Fane's Employee Benefits Group can assist health plan sponsors in understanding and responding to this regulatory guidance.

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